# PATIENT REGISTRATION FORM

**(Please complete if your last visit was before 4/20/15)**

**Date of Service:**_______________ **Service Location:**_______________

## PATIENT INFORMATION (Please provide your MOST CURRENT information.)

Patient's Name:_______________
(first) (middle initial) (last)

Parent/Guardian's Name:_______________
(first) (middle initial) (last)

Patient's Social Security #:_______________ Date of Birth:_______________ Sex:_______ Race:_______

Patient's Address:_______________
(street)

City:_______________ State:_______________ Zip Code:_______________

Contact #: Home #:_______________ Cell #:_______________

Work #:_______________ Other #:_______________

Patient's Email:_______________

Emergency Contact Name:_______________ Relationship to Patient:_______________

Emergency Contact #: Home #:_______________ Cell #:_______________

Work #:_______________ Other #:_______________

## INSURANCE INFORMATION (Please present current insurance card to the FHCGA representative.)

[ ] Medicaid [ ] Amerigroup [ ] Care Source [ ] PeachState [ ] WellCare [ ] Medicare [ ] Medicare supplement

[ ] Private insurance [ ] ACA Marketplace/Exchange [ ] Worker's Comp [ ] Disability [ ] Liability [ ] Other

Please indicate insurance company's name for private insurance:_______________

Member's Name (as listed on insurance card):_______________ Policy #:_______________

PLEASE COMPLETE BACK PAGE
SIGNATURE REQUIRED


Continued on Back Side

## PERSON RESPONSIBLE FOR PAYMENT (This section must be completed even if you are using Medicaid, Medicare, or private insurance.)

Relationship to patient (please check one): [ ] Self [ ] Parent/Guardian [ ] Spouse [ ] Other (specify)________

**[ ] Check here if patient (self) is the responsible person and the information is the same as previously indicated. Only complete section below if any information is different.**

Responsible Party's Name:______________________________________________
(first) (middle initial) (last)

Responsible Party's Address:______________________________________________
(street)

City:________________________ State:________________ Zip Code:____________

Responsible Party's Contact #: Home #:________________ Cell #:________________

Work #:________________ Other #:________________

Responsible Party's Date of Birth:____________ Responsible Party's Social Security #:________________

Responsible Party's Email:______________________________________________

Responsible Party's Insurance Company's Name:______________________________

Member Name (as listed on insurance card):________________________ Policy #:____________

Responsible Party's Employer's Name:______________________________________

Employer's Address:______________________________________________

City:________________________ State:________________ Zip Code:____________

Telephone #:____________ Fax #:____________ Email:________________________

## SIGNATURE REQUIRED (Please read and sign below.)

I, the undersigned, do hereby expressly guarantee payment in full of any and all charges in consideration for the healthcare services rendered, or to be rendered, by THE FAMILY HEALTH CENTERS OF GEORGIA, INC. I also acknowledge that I am solely responsible for payment of any services as billed by an independent provider.

**X** Signature:______________________________________________ Date:____________

# AUTHORIZATION FOR TREATMENT

The Family Health Centers of Georgia, Inc. (FHCGA) is required by law to obtain consent to treat and disclose all material risks and alternative medical treatments. I understand that it is not possible to list every material risk for every procedure or medical treatment and that this form only attempts to identify the most common material risks and the alternatives associated with the procedures or medical treatments.

Medical treatments and/or procedures may include, but are not limited to the following:

1. Needle sticks, such as injections (shots). The material risks associated with these types of procedures include, but are not limited to, nerve damage, infection or bruising. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective); or refusal of medical treatment.

2. Physical tests, assessments and medical treatments (e.g. vital signs, internal body examinations, wound cleaning, wound dressing, range of motion checks); and other similar procedures. There are no known major risks associated with these procedures. Medical treatment may consist of treatment for illnesses (e.g., strep throat, ear infections, pink eye, scrapes, strains, cuts, well child checks).

3. Administration of medications whether orally, rectally, topically or through the eye, ear or nose. The material risks associated with these types of procedures include, but are not limited to, perforation, puncture, infection, or allergic reaction. Apart from varying the method of administration and/or refusal of medical treatment, no practical alternatives exist.

4. Drawing blood, bodily fluids or tissue samples such as that done for laboratory testing and analysis. The material risks associated with these types of procedures include, but are not limited to, infection, bleeding or nerve damage. Apart from varying long-term observation and/or refusal of medical treatment, no practical alternatives exist.

**BY SIGNING THIS FORM:**

- I **consent to FHCGA healthcare professionals performing medical treatments and procedures** as they deem reasonably necessary in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained.
- I acknowledge that I have been informed in general terms of the nature and purpose of the medical treatments and procedures, the material risks of procedures, and practical alternatives to the procedures.
- If I have any questions or concerns regarding these medical treatments or procedures, I will ask my physician to provide me with additional information.
- In order to insure medication safety and lack of drug interactions, I grant FHCGA, its staff and authorized affiliates the right to access my pharmacy and prescription information.
- I understand that it is my choice to receive voluntary confidential family planning services.
- I acknowledge that I have read and understand the above information and I give permission for myself or my child's healthcare as described.

**X** Signature of Patient (or authorized representative): ______________________________

Printed Name of Patient:______________________________ Date:______________________

Relationship to patient:______________________ Reason Patient Unable to Sign (if applicable): __________

Acknowledgment of receipt of Notices of Privacy Practices for Protected Health Information (HIPAA): I acknowledge that I have received the Notice of Privacy Practices.

**X** Signature of Patient (or authorized person to sign): __________________ Date:______________________

Authorization for **medical treatment by Mid-Level Providers**: I understand that The Family Health Centers of Georgia, Inc. and its affiliates utilizes certified Mid-Level Providers (e.g., Physicians Assistants (PA), Nurse Practitioners (NP), etc.) to treat patients for the level of care for which they have been approved by the Georgia State Board of Medical Examiners. My signature on this form conveys that I am in agreement with being treated by a Mid-Level Provider, who is acting under the direct supervision of a physician.

**X** Patient Signature (or authorized representative): __________________ Date:______________________